STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

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F0000	This visit was for the Investigation of Complaint IN00093338. Complaint IN00093338 substantiated, Federal/State deficiency related to allegation is cited at F323. Survey date: July 18, 2011 Facility number: 000137 Provider number: 155232 AIM number: 100266140 Surveyor: Jeri Curtis, RN Census bed type: SNF: 5 SNF/NF: 52 Total: 57 Census payor type: Medicare: 5 Medicaid: 52 total: 57 Sample: 3 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/19/11 Cathy Emswiller RN	F0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. **F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** 1. Resident A was not affected negatively. She was relocated to a secured unit. 2. All newly admitted residents were reviewed for potential elopement risk and necessary interventions taken. The two other residents identified for elopement risk continue to be assessed for exit seeking behaviors and appropriate precautions put in place	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			immediately to assure adequate supervision. Signs were hung at all entrances/exits to alert visitors to ensure that they leave facility unattended by residents. Additionally, a letter was sent to all resident family members/responsible parties to alert them to potential exit seeking residents.(Attachment A) (Attachment B) 3. The entire staff were immediately re-educated in regards to Missing Resident & Elopement Procedures as well as evaluation, assessment and supervision of potential exit seeking residents. The two other residents identified for elopement risk continue to be assessed for exit seeking behaviors and appropriate precautions put in place immediately to assure adequate supervision. Signs were hung at all entrances/exits to alert visitors to ensure that they leave facility unattended by residents. Additionally, a letter was sent to all resident family members/responsible parties to alert them to potential exit seeking residents. Continue to monitor door alarms per action plan.(Attachment A, B and C pg.1-5) 4. As a means to ensure ongoing compliance, administrative staff or designee	

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			will audit all potential and newly admitted residents to assure that they are thoroughly assessed for potential elopement risk in an effort to ensure necessary interventions are implemented This will be completed weekly for four weeks, then twice a month for two months, then monthly for 3 months then quarterly thereafter. (Attachment D pg. 1-2) Results of these reviews will be discussed during the facility's quarterly QA meetings and a plan of action adjusted accordingly. Correction date: July 22, 2011	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure supervision was provided to prevent an elopement for 1 (Resident A) of 3 residents, among the sample of 3, reviewed for elopement risk. Findings include: During the 7/18/11, 8: 55 A.M., entrance conference, the Administrator indicated a recent elopement of Resident (A). The Administrator indicated the police were notified and staff were aware of the	F0323	July 27, 2011 To Whom It May Concern: I respectfully request that you accept our plan of correction for Complaint Survey (IN00093338). Enclosed you will find the systematic changes put in place to ensure the deficient practice does not recur. We would like to respectfully request that you consider paper compliance for the above complaint survey. Sincerely, Tamara Smith, HFA Health Facility Administrator	07/22/2011

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	elopement within 15 minutes of the time Resident (A) was last seen in the facility. The Administrator indicated the Social Services Director (SSD) came to the facility while her (the SSD's family), who had heard of a motor vehicle incident on the police scanner, searched the community. The Administrator indicated Resident (A) had been pre-assessed prior to the 7/8/11, admission and did not have a prior history of elopement. The Administrator indicated after being found by the police and taken to an area hospital for an evaluation, Resident (A) was transferred to a sister facility (NF #2) and placed in a secured unit. The facility's 7/9/11, reportable incident with follow-up was provided by the Administrator 7/18/11, and indicated Registered Nurse (RN #1) was unable to locate Resident (A) for administration of a mantoux (tuberculin) test at 6:50 P.M., 7/8/11, and called a code silver (facility code for search /missing resident). Documentation indicated the SSD and certified nursing assistant (CNA #1), who worked in medical records, immediately began searching the facility grounds. Documentation indicated at 7:17 P.M., the daughter of the SSD notified her (SSD) the local police and emergency medical services (EMS) had picked up a confused			

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	person, who in fact was (Resident A). Documentation indicated Resident (A) was transferred to a hospital for evaluation, accompanied by the SSD. Documentation indicated after further investigation it was determined Resident (A), who had been admitted at 1:00 P.M., 7/8/11, was last seen in the lounge at 6:45 P.M., 7/8/11, and exited the facility with a visitor. The immediate action taken included relocation to a secured unit in NF #2 until further assessment of elopement risk and/or exit seeking behavior could be determined. The Administrator provided her 7/8/11, investigative notes on 7/18/11. Documentation indicated the Administrator was advised at 7:08 P.M. by the Director of Nursing (DoN) by telephone, Resident (A) was missing from the facility. The Administrator advised staff to call in the SSD. Documentation indicated the Administrator spoke to the SSD by telephone at 7:13 P.M., and advised her to call the police if facility staff were unable to locate Resident (A). Documentation indicated the Administrator was notified at 7:27 P.M., 7/8/11, by telephone by the DoN Resident (A) had been found by the police 2 miles from the facility.			

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	The Administrator documented after Resident (A) was found staff were instructed to check all alarmed exits for function and to determine what visitors had been at the facility during the time frame. Documentation indicated at 8:01 P.M., the Administrator had notified the SSD of the bed availability at NF #2 and had instructed her (SSD) to accompany Resident (A) there. The Administrator documented the SSD had said Resident (A) had told the responding EMS she was going to church because her husband had beaten her. The SSD was interviewed at 10:20 A.M., 7/18/11, and indicated the evening of 7/8/11, she had been out to eat with her daughter and other family when she received the call to go the facility and help search for Resident (A). The SSD indicated she had given her daughter a description of Resident (A) and had asked her to search the area by car. The SSD indicated before 7:30 P.M., her daughter had called and said the police and EMS had responded to 10th street and 400 East (2 miles from the facility) to a possible motor vehicle accident involving a woman. The SSD indicated she then called the police and inquired if the woman was (name of Resident A).			

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	The SSD indicated the police had responded yes, the woman was (Resident A). The SSD indicated she then went to the area hospital to be with Resident (A). The SSD indicated when she inquired what happened, Resident (A) had responded she had gone for a walk. The SSD indicated because (Resident A) was new and did not know the facility lay-out, she had described the environment around each door to determine where Resident (A) had exited. The SSD indicated Resident (A) had said yes to the door with the canopy (the front entrance). The Admissions Coordinator was interviewed by telephone at 11:00 A.M., 7/18/11, and indicated Resident (A) had been admitted from a group home on 7/8/11. The Admissions Coordinator indicated the group home case worker had said Resident (A) had marital problems and had experienced a mental break down. The Admissions Coordinator indicated during 2/11, Resident (A) had returned to the group home from a leave of absence with a conation change, no memory. The Admissions Coordinator indicated there was no history of exit seeking. The Admissions Coordinator indicated the spouse of Resident (A) had placed her in a mental health facility, then in 3/11, a nursing facility (NF#3). The Admissions			

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	Coordinator indicated while at NF #3, Resident (A) had run from the facility, chasing her spouse as he left. The Admissions Coordinator indicated NF #3 had refused to keep Resident (A) after she had exited from the facility to chase the spouse. RN #1 was interviewed 7/18/11, at 11:15 A.M., and indicated she had done the initial admission assessment earlier that day, at 1:00 P.M. RN#1 indicated Resident (A) had seemed confused and had said she could not stay at the facility because she had to go check on her brother's farm. RN #1 indicated she had done the vital signs and had assessed the skin. RN #1 indicated Resident (A) had a slow, steady, gait. RN #1 indicated Resident (A) had spoken with 2 other residents and had requested to sit with them at the evening meal. RN #1 indicated she had seated Resident (A) at a table and had taken her meal tray to her at 5:00 P.M., 7/8/11. RN #1 indicated she had to monitor the dining room until all residents had left, and at 6:30 P.M., had gone to the room of Resident (A) to administer the mantoux. RN #1 indicated she had looked about for Resident (A), and at 6:45 P.M., had asked other staff to search the facility and			

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	grounds. RN #1 indicated she knew what Resident (A) had been wearing, stripped pajama style pants and a spaghetti strap camisole top. RN #1 indicated she was unsure, but thought Resident (A) had on slippers. RN #1 indicated all the exits were alarmed. RN #1 indicated no one had heard an alarm other than at the smoking exit, which opened onto a locked, fenced, patio. RN #1 indicated she was new and still learning procedures. RN #1 indicated another resident (B) had talked about leaving and had been placed on 15 minute checks, then 1:1 staffing. RN #1 indicated she was unsure if the statement about leaving for her brothers farm should have required 1:1 staffing for Resident (A). The record of Resident (A) was reviewed at 11:30 A.M., 7/18/11, and indicated diagnoses including, but were not limited to, severe depression with panic attacks, and a history of a brain tumor with seizures. The 7/8/11, 1:00 P.M., admission nursing note indicated Resident (A) had arrived by the group home van. The next nursing note documentation was at 6:45 P.M., 7/8/11, indicating staff was unable to locate Resident (A) and a code was called per policy. Documentation indicated the building and outside			

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	parameters were searched and the DoN was notified. The next documentation was at 7:08 P.M., 7/8/11, which indicated Resident (A) had been found and an ambulance was transporting (Resident A) to the area hospital. The 7/8/11, 7:30 P. M., nursing note indicated physician notification. The last documentation was at 8:30 P.M., 7/8/11, indicating Resident (A) was being transferred to NF #2. Documentation did not indicate an elopement risk, or other admission assessments. A 7/6/11, pre-admission assessment, had been conducted by the Admissions Coordinator and indicated a sister (only the first name listed without an address or telephone number) , as the responsible party. The assessment indicated Resident (A) had been at the group home since 6/6/11. Resident (A) was assessed as walking safely with a stumbling gait. The transfer assistance assessment indicated, "help maybe." Documentation indicated Resident (A) was tearful throughout the assessment interview and referred to things in the past. The assessment history indicated the 2/11, placement at NF #3, with Resident (A)			

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	exiting the facility to follow the spouse. Documentation indicated NF #3 then declined to keep Resident (A) and had requested the spouse return her to the group home. During a 7/18/11, 1:00 P.M., interview, the Administrator indicated she was unaware Resident (A) had made a statement about not remaining in the facility on her admission. The Administrator indicated it might have triggered 15 minute checks or 1:1 staffing. The Administrator indicated each resident's behavior was on a case by case basis. The Administrator also indicated although the facility was located in town, 5-6 blocks down the street was a t-road. The Administrator indicated if you turned right it led toward a highway and the town if you turned left it headed into the country. The Administrator indicated Resident (A) had apparently turned left. A visit was made to NF #2 at 1:45 P.M., 7/18/11. Resident (A) was observed in her room in the secured unit, resting in bed. Resident (A) had no recall of leaving NF #1 and was unable to state where she was presently. Family member #1 was at the bedside visiting. Family member #1 indicated the case worker at the group home had called			

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	her the evening of 7/8/11, after Resident (A) had been found, to notify her of the elopement. Family member #1 indicated she was told Resident (A) had gone to a farmer's house, knocked on the door and had said she needed help. Family member #1 indicated the initial emergency response call had been a motor vehicle accident because of (Resident A) being alone along a country road. The 7/8/11, admission assessment to NF #2, was reviewed at 2:00 P. M., 7/18/11, and indicated a blood pressure of 98/54, pulse 70, and a reddened, dry, skin condition. Documentation indicated no rashes or open areas. The facility's 9/05, Missing Resident & Elopement Procedure was provided by the Administrator 7/18/11. The purpose was to assure the whereabouts of all residents would be known at all times and safely maintained. This federal tag relates to Complaint IN00093338. 3.1-45(a)(2)			